

**6 10 Y**

EPSDT  
 Screening Date

2 0 0

Member  
 ID#

— — — — —

# 6 to 10 Year Visit

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Historian \_\_\_\_\_

Age \_\_\_\_\_ Allergies \_\_\_\_\_ Medications \_\_\_\_\_

Weight \_\_\_\_\_ lbs Length \_\_\_\_\_ inches BP \_\_\_\_\_ Temp. \_\_\_\_\_ T O

## History Update

Changes in your family history? No Yes

Has the patient had any new problems or illnesses since the last visit? No Yes

FH heart disease < 55 No Yes

FH ↑ cholesterol No Yes

## Problems / Parental Concerns

## Nutrition

Low fat milk? yes no

Variety of fruits/vegetables? yes no

Eats breakfast? yes no

Eats supper with family? yes no

## Hearing (test at age 10 or every 5 yrs if nl)

Hearing screen pass fail

Date \_\_\_\_\_

## Vision (test every two years)

L near 20/ \_\_\_\_\_ far 20/ \_\_\_\_\_

R near 20/ \_\_\_\_\_ far 20/ \_\_\_\_\_

Wears glasses, sees eye specialist

School Grade \_\_\_\_\_

Problems? Yes No

TB Risk Factors\* yes no

(see separate form)

IPPD result \_\_\_\_\_

## Lab Tests

Hgb

If abnormal or not done at age 5 years.

Cholesterol \_\_\_\_\_

If risk factors and not done at age 5 yrs.

Urinalysis (If abnl. or not done at 5 yrs.)

see back for results

\*see separate form

Physical Exam (UNCLOTHED)	Yes	No	✓ = nl	X = abnl
General	<input type="checkbox"/>			
Head	<input type="checkbox"/>			
Neck	<input type="checkbox"/>			
Eyes	<input type="checkbox"/>			
Ears	<input type="checkbox"/>			
Nose	<input type="checkbox"/>			
Throat/Mouth/Teeth	<input type="checkbox"/>			
Chest	<input type="checkbox"/>			
Breasts/Tanner Stage				
Lungs	<input type="checkbox"/>			
Heart	<input type="checkbox"/>			
Abdomen	<input type="checkbox"/>			
Femoral Pulses	<input type="checkbox"/>			
Genitalia /Tanner Stage				
Female	<input type="checkbox"/>			
Male	<input type="checkbox"/>			
Extremities	<input type="checkbox"/>			
Spine	<input type="checkbox"/>			
Skin	<input type="checkbox"/>			
Neuro	<input type="checkbox"/>			

## Safety

Smoke detectors, no smoking in home

Buckle up!

Booster seat < 58", < 70#

Bike helmet, street safety

Water safety, swimming lessons

Firearm safety

Sunburn prevention

## Health/Nutrition

Low fat milk and snacks

Encourage fruits and vegetables

Brush teeth, see dentist

Encourage sports, active play

## Social/Behavioral

School adjustment, performance

Sports and hobbies

Limit TV, computer games

Give choices, encourage independence

Set limits, provide consequences

Privacy, personal hygiene

Puberty changes and ? about sex

Family relationships

Friends and schoolmates

Dealing with strangers

Developmental/Behavioral

Screen\*

Provider ID#

## Impression

Well Child, normal growth and development

\_\_\_\_\_

\_\_\_\_\_

## Plan/Referrals

Immunizations current yes no

RTC at \_\_\_\_\_ years

See dentist \_\_\_\_\_

Handouts \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
 M.D. / P.N.P.

See back for additional documentation

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